

AUM STUDENT HEALTH CENTER

PATIENT INFORMATION (PLEASE PRINT LEGIBLY)

Date: 04/26/2018 Are you an AUM Student? ☐ Yes ☒ No S-Number: _____

Name: Paula Diaz Birthdate: 02/27/1996

Main Phone Number: 832 677 5036 Alternate Phone Number: _____

Local Mailing Address: 401 17th street NW Box or APT #: Apt 5411

City: ATL State: GA Zip Code: 30363

Permanent/Home Address: 401 17th street NW Box or APT #: Apt. 5411

City: ATL State: GA Zip Code: 30363

Marital Status (Please Circle): Single Married Divorced Widowed Other: _____

Sex (Please Circle): Male Female Gender: Male Female

Primary Physician: _____ City: _____ Phone #: _____

Patient's Employer: _____ Work Phone #: _____

Parent's or Spouse's Name (Circle which): Oscar Diaz Phone #: +58 416 650 4441

Parent's or Spouse's Employer: _____ Phone #: _____

Emergency Contact: Pedro Cabrera Relationship: Uncle Phone #: +1 214 681 9720

How did you hear about the clinic (Circle which): Friend Faculty/Staff Orientation Other: _____

INSURANCE INFORMATION

Do you have health insurance? ☐ YES ☒ NO

If yes, please give your card to the front desk in order for a copy to be made for your chart.

Insurance Company: _____ Name on Card: _____

Policy or Contract Number: _____ Group Number: _____

Insurance Company's Address: _____

AUM STUDENT HEALTH CENTER

CONSENT FOR SERVICES FORM

Patient Name: Paola Diaz Date of Birth: 27 / 02 / 95
Day Month Year

General Consent for Treatment

I request and authorize health care services by my provider and his/her designees(s) as my provider may deem advisable and in my best interest. This may include routine diagnostic, laboratory procedures, and administration.

I understand that excluding emergency or extraordinary circumstances, no substantial procedure will be performed without providing me an opportunity to give me informed consent for that procedure. Informed consent means that the medical provider must disclose information to me including benefits and risks of a particular procedure and/or treatment.

Payment

I am responsible for all bills incurred at the Student Health Center. Payment is due at the time that services are rendered unless prior arrangements have been made.

I have read the consent form, or it has been read to me, and I am satisfied that I understand its contents. My questions have been answered to my satisfaction.



Signature of Patient

26 / 04 / 2018
Day Month Year

Date of Signature

Signature of Legal Representative (if patient is unable to sign)

Relationship to Patient

AUM Student Health Services
Medical Information Release Form
(HIPPA Release Form)

Name: Paula Diaz Date of Birth 02/27/95

Release of Information

[] I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information. This information may be released to:

[] Spouse: _____

[] Child(ren): _____

[] Other: _____

☒ Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [] my home [] my work ☒ my cell number: (832)-677-5036

If unable to reach me:

[] you may leave me a detailed message

☒ please leave a message asking me to return your call

[] other: _____

The best time to reach me is (day or days) Monday, Tuesday, Wednesday between 4pm and 6pm times.

Signed: _____

Date: 04/26/18

AUM Student Health Services

PATIENT HIPPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involve in my treatment)
- Obtaining payment from third party payers (e. g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your *Summary of the HIPPA Privacy Rule*, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree with these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this 26 day of April 20 18.
(day) (month) (last two digits of the year)

Print Patient's Name: Raula Diaz

Signature: [Signature]

Relationship to Patient (if you are the patient, write "self"): _____